l. If a beneficiary, who is enrolled in the Medicaid Managed Care Organization (MCO) and is also required to participate in its Pharmacy Lock-In Program, subsequently becomes enrolled in the Medicaid Fee-For-Service Program, that beneficiary will be automatically enrolled in the Medicaid Fee-For-Service Pharmacy Lock-In Program. The lock-in will remain in force for a period not to exceed the length of the initial lock-in period first imposed by the MCO, or twelve (12) months, whichever is less.

(10) Medication Assisted Treatment (MAT) under Adult Substance Abuse Rehabilitative Services (described in Supplement 6 to Attachment 3.1-A)

a. MAT is the use of pharmacotherapies (e.g., methadone) as long-term treatment for opiate or other forms of dependence. MAT includes medication dosing used in conjunction with Substance Abuse Counseling.

b. Unit of Service: One unit consists of one (1) dose of medication per day.

c. Limitations: Prior approval from the Department of Health Addiction Prevention and Recovery Administration (APRA) or its designee is required prior to enrollment in MAT. The maximum number of MAT services available over a twelve (12) month period is three hundred sixty-five (365) units.

Beneficiaries receiving MAT will require two (2) prior authorizations from APRA or its designee before long-term maintenance can be authorized. A new patient shall have an initial authorization of up to ninety (90) units of daily medications. The provider must then request authorization for an additional ninety (90) units, if appropriate, after which the patient may receive authorization for long-term MAT up to one hundred eighty (180) units.

d. Location/Setting:
Substance abuse treatment facility or program certified by APRA or community-based setting otherwise approved or designated by APRA.

Buprenorphine Only: Private practice offices of individuals authorized to prescribe buprenorphine according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*).

e. Qualified Practitioners: Licensed practitioners, including: Qualified Physicians or APRNs and PAs who are supervised by qualified Physicians

(3) Special glasses such as sunglasses and tints must be justified in writing by the ophthalmologist or optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

(4) Contact lenses must be prior authorized by the State Agency.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services, i.e., Other Than Those Provided Elsewhere in This Plan

a. Diagnostic services must be prior authorized.

b. Screening services are limited to eligible EPSDT recipients.

c. Preventive services must be prior authorized.

d. Rehabilitative services must be prior authorized and are covered for eligible Medicaid beneficiaries who are in need of mental health or substance abuse treatment, due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: 1) Mental Health Rehabilitation Services (MHRS); and 2) Adult Substance Abuse Rehabilitative Services (ASARS).

These services are described in Supplement 6 to Attachment 3.1-A.

**STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

## 13. Other Diagnostic, Screening, Preventive, and Rehabilitative Services i.e., Other Than Those Provided Elsewhere in this Plan

a. Diagnostic Services must be prior authorized.

b. Screening Services are limited to eligible EPSDT recipients.

c. Preventive Services must be prior authorized.

d. Rehabilitative Services are covered for Medicaid eligible individuals who are in need of mental health or substance abuse services due to mental illness, serious emotional disturbance, or substance use disorder. Covered services include: 1) Mental Health Rehabilitation Services and 2) Adult Substance Abuse Rehabilitative Services.

1. **MENTAL HEALTH REHABILITATION SERVICES ("MHRS")** are provided to all Medicaid eligible individuals who are mentally ill or seriously emotionally disturbed and in need of mental health services; and elect to receive, or have a legally authorized representative select on their behalf, mental health Rehabilitation Option services ("mental health rehabilitation services"). Services include:

   i. Diagnostic/Assessment
   ii. Medication/Somatic Treatment (Individual and Group)
   iii. Counseling (Individual On-Site, Individual Off-Site and Group)
   iv. Community Support (Individual and Group)
   v. Crisis/Emergency
   vi. Day Services
   vii. Intensive Day Treatment
   viii. Community-Based Intervention
   ix. Assertive Community Treatment

   Services are intended for maximum reduction of mental disability and restoration of a recipient to his or her best possible functional level. Services are recommended by a physician or a licensed practitioner of the healing arts, and are rendered by, or under the supervision of, Qualified Practitioners in certified community MHRS agencies, in accordance with standards established by the Department of Mental Health ("DMH") as set forth in the District of Columbia Code of Municipal Regulations. Those standards include, but are not limited to, the following:

   - Each MHRS provider shall be certified as a Community MHRS Agency by DMH;
   - Each MHRS provider shall demonstrate the administrative and financial management capability to meet District of Columbia and federal requirements;
   - Each MHRS provider shall demonstrate the clinical capacity and ability to provide services to individuals needing MHRS;
   - Each MHRS provider shall develop policies and procedures for handling routine, urgent and emergency situations, including referral procedures to local emergency departments, staff assignments to cover emergency walk-in hours and on-call arrangements for clinical staff and physicians;

**STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

2. **ADULT SUBSTANCE ABUSE REHABILITATIVE SERVICES ("ASARS")** are available to Medicaid eligible individuals who elect to receive, have legally authorized representatives select on their behalf, or are otherwise legally obligated to seek medically necessary treatment for Substance Use Disorder ("SUD"). SUD is comprised of: 1) Substance Abuse and 2) Substance Dependence.

Substance Abuse is a maladaptive pattern of substance use, including alcohol, illicit drugs, and pharmaceuticals. Substance Abuse is manifested by recurrent and significant adverse consequences, including: 1) failure to fulfill obligations; 2) repeatedly subjecting one's self to physical hazards; 3) multiple legal problems; and 4) social and interpersonal issues. A Substance Abuse diagnosis requires a beneficiary to have had persistent, substance-related problem(s) within a 12-month period.

Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms that indicate persistent use of a substance. Substance Dependence is manifested by a repeated pattern of self-administration of substances that results in physical tolerance, withdrawal symptoms, and compulsive substance consumption. A diagnosis of Substance Dependence requires a beneficiary to have had persistent, substance-related problem(s) within a 12-month period.

ASARS are intended to reduce or ameliorate both forms of SUD through therapeutic interventions that assist a beneficiary to restore maximum functionality. ASARS treatment includes the following services:

i. Assessment/Diagnostic
ii. Clinical Care Coordination
iii. Crisis Intervention
iv. Substance Abuse Counseling
v. Medically Managed Intensive Inpatient Detoxification
vi. Medication Management
vii. Medication Assisted Treatment

**ASARS PROGRAM ASSURANCES**

As the single state agency for the administration of the medical assistance program, the Department of Health Care Finance ("DHCF") assures state-wideness and comparability for ASARS treatment. Additionally, Medicaid beneficiaries shall maintain free choice of providers for ASARS treatment facilities, programs, and practitioners in accordance with 42 C.F.R. § 431.51.

The Medicaid eligibility determination process will facilitate assurance that there will be no duplication of services or claiming between fee-for-service ASARS treatment and any substance abuse treatment services delivered through Medicaid managed care contractors.

A facility where residential ASARS treatment is delivered shall be limited to having sixteen (16) beds or less, and be sufficiently geographically disparate as to not be considered an institution for mental diseases ("IMD").

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## ASARS PROGRAM EXCLUSIONS

Medicaid Reimbursement for ASARS treatment is not available for the following:

- Treatment for inmates in public institutions, as defined in 42 C.F.R. § 435.1010;
- Services provided in nursing facilities, ICFs/ID, and IMDs;
- Room, board, and transportation costs;
- Services delivered as a component of human subjects research and/or clinical trials;
- Educational, vocational and job training services;
- Services rendered by parents or other family members;
- Legal services;
- Strictly social or recreational services;
- Services covered elsewhere in the District's State Plan, including habilitative and mental health rehabilitative services; and
- Services which are not medically necessary.

## ASARS PROVIDER QUALIFICATIONS

In accordance with 42 C.F.R. § 440.130(d), ASARS shall be recommended by qualified physicians or other practitioners of the healing arts who are qualified to deliver substance abuse treatment services as defined by the scope of practice in the state in which the individual is licensed.

**Qualified practitioners *eligible to diagnose SUD* include**: Qualified Physicians; Psychologists; Licensed Independent Clinical Social Workers ("LICSWs"); and Advanced Practice Registered Nurses ("APRNs") when working collaboratively with a Physician to provide Assessment/Diagnostic services.

**Qualified practitioners *eligible to deliver non-diagnostic ASARS services* include**: Qualified Physicians; Psychologists; LICSWs; APRNs; Licensed Independent Social Workers ("LISWs"); Licensed Professional Counselors ("LPCs"); and Certified Addiction Counselors ("CACs I and II").

**Licensed Professional Counselors ("LPCs")** shall be licensed by the District of Columbia Department of Health ("DOH"), pursuant to Chapter 66 of Title 17 of the District of Columbia Municipal Regulations ("DCMR").

**Certified Addiction Counselors ("CACs I and II")** shall be licensed by DOH, pursuant to Chapter 87 of Title 17 DCMR.

- Licensure requirements for CACs include educational and experiential components, as well as certification by the National Association of Alcohol and Drug Abuse Counselors – National Certification Commission ("NAADAC-NCC").
- Supervisory CACs shall be advanced practice addiction counselors, LPCs, clinical psychologists, clinical social workers, marriage and family therapists, physicians, or registered nurses; and hold one of the following: 1) current CAC II certification in substance abuse counseling; 2) certification through the NAADAC-NCC or National Board of Certified Counselors ("NBCC"); or 3) have documentation of a minimum of one (1) year of experience in substance abuse counseling and at least one hundred (100) hours of didactic training.

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## ASARS FACILITIES/PROGRAM REQUIREMENTS

In accordance with § 2331.4 of Title 29 DCMR, all substance abuse treatment facilities and programs shall be enrolled as Medicaid providers in order to be eligible for reimbursement.

The DOH Addiction Prevention and Recovery Administration ("APRA") is the state agency responsible for regulating and certifying substance abuse treatment facilities and programs. ASARS shall be delivered in substance abuse treatment facilities and programs that are APRA-certified in one or more of the following categories:

- Non-hospital Inpatient Detoxification, as defined in § 2399 of Title 29 DCMR, and subject to ASARS Program Exclusions described above;
- Non-hospital Residential Treatment;
- Intensive Outpatient Treatment;
- Narcotic/Opioid Outpatient Treatment; and/or
- Outpatient Treatment

Non-hospital facilities and programs delivering ASARS to Medicaid beneficiaries shall be subject to both DHCF and APRA policies, which include, but are not limited to, maintaining standards for:

- Administrative operations in areas such as: practice ethics; quality improvement; policies and procedures; relationships with external entities and contractors; health and safety management; patient rights and privileges;
- Clinical operations in areas such as: levels of patient care standards; intake and screening; rehabilitation/treatment planning; crisis intervention; clinical emergencies; referrals; staff development;
- Protection of patient rights and privileges, including a well-publicized complaint/grievance system; and
- Space, staffing, and financial management, including one (1) mandatory cardiopulmonary resuscitation ("CPR") certified staff member to be present during all hours of operation.

**STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

## ASARS: TREATMENT FRAMEWORK

The treatment framework for ASARS is based on four (4) levels of care established by the American Society for Addiction Medicine ("ASAM"). A typical course of treatment anticipates continuity of services across multiple levels of care, and assumes two factors: 1) that a beneficiary enters treatment at the level of care most consistent with the presenting needs and 2) that subsequent authorizations include all lower levels of care in a graduated fashion.

Delivery of ASARS is based on the treatment episode. The treatment episode is the period between a beneficiary's admission to treatment for SUD and the termination or discharge from services prescribed in the rehabilitation (or treatment) plan, as defined in D.C. Official Code § 7-3002(10). A single treatment episode may include multiple levels of care, subject to the limitations described in "ASARS: Descriptions of Services".

The average lengths of treatment episodes at each level of care are as follows:

**A.** **Level IV**: From three (3) to five (5) days (i.e., Medically Managed Intensive Inpatient Detoxification)

**B.** **Level III**: Approximately twenty-eight (28) days (i.e., Residential Substance Abuse Treatment)

**C.** **Level II:** Thirty (30) to forty-five (45) days

**D.** **Level I**: Approximately one hundred twenty (120) days (excluding Medication Assisted Treatment)

A course of ASARS treatment incorporates interdisciplinary approaches to rehabilitation (treatment) plan development, excluding mental health services. Comprehensive clinical care coordination (CCC) services are intended to improve outcomes by linking a beneficiary to health, medical, and social services that aid addiction recovery.

Due to the chronic nature of SUD, a beneficiary may relapse during a 12-month period after having already completed one (1) full course of treatment (i.e., at least two (2) of the above levels of care). ASARS treatment is organized to allow a beneficiary to access a second course of treatment, in addition to services related to higher levels of care, if relapse occurs. Prior authorization from DHCF is required if relapse requires a beneficiary to repeat treatment in a level of care that was previously received in the same 12-month period.

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## ASARS: DESCRIPTIONS OF SERVICES

i. **Assessment/Diagnostic** services represent initial evaluation, as well as initial and ongoing collection of relevant information about a beneficiary who may require access to ASARS treatment. The assessment instrument shall incorporate ASAM patient placement criteria.

An Assessment/Diagnostic may be 1) Initial; 2) Comprehensive; 3) Ongoing; or 4) Brief. Initial, Comprehensive, and Ongoing Assessment/Diagnostic services include the development and refinement of treatment plans in addition to providing referrals. Brief Assessment/Diagnostic may be used for minor updates to a beneficiary's diagnosis or treatment plan prior to transfer into a different level of care as indicated by progress with ASARS treatment. Brief Assessment/Diagnostic may also be used as a pre-screening for hospitalization and prior to a beneficiary's discharge from ASARS treatment. Initial and Comprehensive Assessment/Diagnostic shall be performed once per treatment episode. Clinical Care Coordinators shall determine the frequency of Ongoing and Brief Assessment/Diagnostic services.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Additional units require prior authorization from DHCF, obtained by submitting a request through APRA. Limitations for Assessment/Diagnostic services, per treatment episode, are as follows:

1. *Initial Assessment/Diagnostic services* are required to determine an individual's need for substance abuse treatment, and shall not exceed four (4) units;
2. *Comprehensive Assessment/Diagnostic services* are required in order to initiate a treatment episode, and shall not exceed sixteen (16) units;
3. *Ongoing Assessment/Diagnostic services* shall not exceed ninety-two (92) units; and
4. *Brief Assessment/Diagnostic services* shall not exceed eight (8) units.

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs

**D.** Qualified Practitioners: Assessment/Diagnostic services may be provided by qualified practitioners as follows:

1. *Initial Assessment/Diagnostic services* shall be provided by the following: Qualified RNs, LISWs, LPCs, and CACs I and II.
2. *Comprehensive, Ongoing, and Brief Assessment/Diagnostic services* shall be provided by the following: Qualified Physicians, Psychologists, LICSWs and APRNs.

**STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

ii. **Clinical Care Coordination ("CCC")** is the initial and ongoing process of identifying, planning, coordinating, implementing, monitoring, and evaluating options and services to best meet a beneficiary's health needs during ASARS treatment. CCC focuses on linking beneficiaries across the levels of care indicated in the treatment plan, and is intended to facilitate specified outcomes that will restore a beneficiary's functional status in the community. CCC includes the identification of interventions that are consistent with the diagnosis, and monitoring compliance with appointments and participation in activities defined in the treatment plan.

Each Medicaid beneficiary receiving ASARS treatment shall be assigned a Clinical Care Coordinator. Clinical Care Coordinators are required to participate in a beneficiary's interdisciplinary team meetings in order to identify opportunities to further develop and/or update the treatment plan.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Limitations for CCC, per treatment episode, are as follows:

1. Level IV: Sixteen (16) units;
2. Level III: Sixty-four (64) units;
3. Level II: Ninety-six (96) units;
4. Level I: One-hundred ninety two (192) units
   Beneficiaries at level 1 and receiving long-term Medication Assisted Treatment (MAT) (methadone/buprenorphine) are allowed an additional sixteen (16) units during a treatment episode.

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs or community-based setting otherwise approved or designated by APRA

**D.** Qualified Practitioners: Qualified substance abuse counselors, limited to: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs II.

Clinical Care Coordinators, except Qualified Physicians and Psychologists, shall provide CCC under the supervision of the following practitioners: 1) LICSW; 2) APRN or RN certified in chemical dependency; 3) a supervisory CAC II; or 4) an individual with a Bachelor's degree from an accredited college or university in social work, counseling, psychology, or a closely related field, and at least two (2) full years of experience.

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iii. **Crisis Intervention** is an immediate, short-term substance abuse treatment approach that is intended to assist a beneficiary to resolve a personal crisis. Crises are events that significantly jeopardize treatment, recovery progress, health, and/or safety.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Allowable units per 12-month period are based on the following level of care structure:

1. Level IV: Thirty-two (32) units;
2. Level III: One hundred sixty (160) units;
3. Level II : One hundred twenty (120) units;
4. Level I: Eighty (80) units

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs and community-based setting otherwise approved or designated by APRA

**D.** Qualified Practitioners: Qualified substance abuse counselors, including: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs I and II

iv. **Medically Managed Intensive Inpatient Detoxification ("MMIID"), or Level IV Care,** is 24-hour, medically directed evaluation and withdrawal management. The service is for beneficiaries with sufficiently severe signs and symptoms of withdrawal from psychoactive substances such that primary medical and nursing care services are necessary.

Beneficiaries discharged from MMIID treatment shall be directly admitted into a residential substance abuse program through a "bed-to-bed" transfer unless APRA previously authorized an exception, or the client refuses admission to a residential program.

**A.** Unit of Service: A unit of service is equivalent to one (1) day as an inpatient

**B.** Limitations: An MMIID stay shall not exceed five (5) days without prior authorization from DHCF. The maximum for MMIID services is ten (10) units per treatment episode. Additional units shall be requested through APRA and prior authorized by DHCF.

**C.** Location/Setting: Free-standing, non-hospital, APRA-certified substance abuse treatment facilities/programs meeting the standards for medical detoxification personnel, as set forth in § 2364 of Title 29 DCMR.

**D.** Qualified Practitioners:

1. Licensed Physicians; or
2. Psychologists, RNs, LICSWs, APRNs, LPCs, or CACs II under the direction and supervision of a Qualified Physician and in accordance with applicable District of Columbia professional licensing laws

**STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

v. **Substance Abuse Counseling (Individual, Group, and Family)** is a face-to-face, interactive process conducted in individual, group, or family settings and focused on assisting a beneficiary who is manifesting SUD.

The aim of Substance Abuse Counseling is to cultivate the awareness, skills, and supports to facilitate long-term recovery from substance abuse. Substance Abuse Counseling addresses the specific issues identified in a treatment plan. Substance Abuse Counseling shall be conducted in accordance with the requirements established in 29 DCMR §§ 2340, 2341, and 2343 as follows:

Individual Substance Abuse Counseling is face-to-face interaction with a beneficiary for the purpose of assessment or supporting the patient's recovery. 29 DCMR § 2340

Group Substance Abuse Counseling facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; and develops motivation through peer pressure, structured confrontation and constructive feedback. 29 DCMR § 2341

Family Substance Abuse Counseling is planned, goal-oriented therapeutic interaction between a qualified practitioner, the beneficiary, and his or her family. A family member is an individual who lives in the same household as the beneficiary and has a significant relationship with him/her. 29 DCMR § 2343

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Substance Abuse Counseling shall not be provided in conjunction with Medication Management. Group and Family Counseling services shall be directed exclusively toward the recovery of a Medicaid beneficiary enrolled in ASARS treatment. Limitations for Substance Abuse Counseling, per treatment episode, are as follows:

1. Level IV: *Individual*: Not to exceed twenty (20) units; *Group*: Not to exceed twelve (12) units; *Family*: Not to exceed four (4) units

2. Level III: *Individual*: Not to exceed thirty-two (32) units; *Group*: Not to exceed eight hundred ninety-six (896) units; *Family*: Not to exceed sixteen (16) units

3. Level II: *Individual*: Not to exceed twenty-four (24) units; *Group*: Not to exceed two hundred sixteen (216) units; *Family*: Not to exceed twenty-four (24) units

4. Level I (Beneficiaries also receiving methadone maintenance or buprenorphine): *Individual*: Not to exceed forty-eight (48) units; *Group*: Not to exceed one hundred ninety-two (192) units; *Family*: Not to exceed twelve (12) units

5. Level I: *Individual*: Not to exceed thirty-two (32) units; *Group*: Not to exceed three hundred eighty-four (384) units; *Family*: Not to exceed sixteen (16) units

Additional allowances for Substance Abuse Counseling services shall be established by the Clinical Care Coordinator, subject to the beneficiary's level of care.

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs; community-based setting otherwise approved or designated by APRA; and private practices with qualified practitioners authorized to provide substance abuse counseling according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*)

**D.** Qualified Practitioners: Substance abuse counselors, including: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs I and II

vi. **Medication Management** is the coordination and evaluation of medications consumed by beneficiaries. It includes monitoring of potential side effects, drug interactions, compliance with doses, and efficacy of medications. Medication Management includes the evaluation of a patient's need for MAT, the provision of prescriptions, and ongoing medical monitoring/evaluation related to the use of the psychoactive drugs.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Medication Management shall not be conducted in conjunction with Substance Abuse Counseling. The maximum for Medication Management is ninety-six (96) units per treatment episode.

**C.** Location/Setting: Substance abuse treatment facility program certified by APRA; or community-based setting otherwise approved or designated by APRA; private practice offices of individuals authorized to provide medication management services according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*)

**D.** Qualified Practitioners: Licensed practitioners, including: Qualified Physicians or APRNs and PAs who are supervised by qualified physicians

vii. **Medication Assisted Treatment ("MAT")** is the use of pharmacotherapy as long-term treatment for opiate or other forms of dependence. MAT includes medication dosing used in conjunction with Substance Abuse Counseling. Beneficiaries enrolled in MAT shall also be enrolled in Substance Abuse Counseling. MAT is described in Supplement 1 to Attachment 3.1-A, page 20.

k. Beneficiaries in skilled nursing facilities, long term care facilities, and intermediate care facilities for the mentally retarded are not eligible for the Pharmacy Lock-In Program.

l. If a beneficiary, who is enrolled in the Medicaid Managed Care Organization (MCO) and is also required to participate in its Pharmacy Lock-In Program, subsequently becomes enrolled in the Medicaid Fee-For-Service Program, that beneficiary will be automatically enrolled in the Medicaid Fee-For-Service Pharmacy Lock-In Program. The lock-in will remain in force for a period not to exceed the length of the initial lock-in period first imposed by the MCO, or twelve (12) months, whichever is less.

(10) Medication Assisted Treatment (MAT) under Adult Substance Abuse Rehabilitative Services (described in Supplement 6 to Attachment 3.1-A)

a. MAT is the use of pharmacotherapies (e.g., methadone) as long-term treatment for opiate or other forms of dependence. MAT includes medication dosing used in conjunction with Substance Abuse Counseling.

b. Unit of Service: One unit consists of one (1) dose of medication per day.

c. Limitations: Prior approval from the Department of Health Addiction Prevention and Recovery Administration (APRA) or its designee is required prior to enrollment in MAT. The maximum number of MAT services available over a twelve (12) month period is three hundred sixty-five (365) units.

Beneficiaries receiving MAT will require two (2) prior authorizations from APRA or its designee before long-term maintenance can be authorized. A new patient shall have an initial authorization of up to ninety (90) units of daily medications. The provider must then request authorization for an additional ninety (90) units, if appropriate, after which the patient may receive authorization for long-term MAT up to one hundred eighty (180) units.

d. Location/Setting:
Substance abuse treatment facility or program certified by APRA or community-based setting otherwise approved or designated by APRA.

Buprenorphine Only: Private practice offices of individuals authorized to prescribe buprenorphine according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*).

e. Qualified Practitioners: Licensed practitioners, including: Qualified Physicians or APRNs and PAs who are supervised by qualified Physicians

(3) Special glasses such as sunglasses and tints must be justified in writing by the ophthalmologist or optometrist. Special tints and sunglasses are not allowed in addition to untinted eyewear.

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   iv. Community Support (Individual and Group)
   v. Crisis/Emergency
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   Services are intended for maximum reduction of mental disability and restoration of a recipient to his or her best possible functional level. Services are recommended by a physician or a licensed practitioner of the healing arts, and are rendered by, or under the supervision of, Qualified Practitioners in certified community MHRS agencies, in accordance with standards established by the Department of Mental Health ("DMH") as set forth in the District of Columbia Code of Municipal Regulations. Those standards include, but are not limited to, the following:

   - Each MHRS provider shall be certified as a Community MHRS Agency by DMH;
   - Each MHRS provider shall demonstrate the administrative and financial management capability to meet District of Columbia and federal requirements;
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TITLE XIX OF THE SOCIAL SECURITY ACT**

2. **ADULT SUBSTANCE ABUSE REHABILITATIVE SERVICES ("ASARS")** are available to Medicaid eligible individuals who elect to receive, have legally authorized representatives select on their behalf, or are otherwise legally obligated to seek medically necessary treatment for Substance Use Disorder ("SUD"). SUD is comprised of: 1) Substance Abuse and 2) Substance Dependence.

Substance Abuse is a maladaptive pattern of substance use, including alcohol, illicit drugs, and pharmaceuticals. Substance Abuse is manifested by recurrent and significant adverse consequences, including: 1) failure to fulfill obligations; 2) repeatedly subjecting one's self to physical hazards; 3) multiple legal problems; and 4) social and interpersonal issues. A Substance Abuse diagnosis requires a beneficiary to have had persistent, substance-related problem(s) within a 12-month period.

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**ASARS PROGRAM ASSURANCES**

As the single state agency for the administration of the medical assistance program, the Department of Health Care Finance ("DHCF") assures state-wideness and comparability for ASARS treatment. Additionally, Medicaid beneficiaries shall maintain free choice of providers for ASARS treatment facilities, programs, and practitioners in accordance with 42 C.F.R. § 431.51.

The Medicaid eligibility determination process will facilitate assurance that there will be no duplication of services or claiming between fee-for-service ASARS treatment and any substance abuse treatment services delivered through Medicaid managed care contractors.

A facility where residential ASARS treatment is delivered shall be limited to having sixteen (16) beds or less, and be sufficiently geographically disparate as to not be considered an institution for mental diseases ("IMD").

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## ASARS PROGRAM EXCLUSIONS

Medicaid Reimbursement for ASARS treatment is not available for the following:

- Treatment for inmates in public institutions, as defined in 42 C.F.R. § 435.1010;
- Services provided in nursing facilities, ICFs/ID, and IMDs;
- Room, board, and transportation costs;
- Services delivered as a component of human subjects research and/or clinical trials;
- Educational, vocational and job training services;
- Services rendered by parents or other family members;
- Legal services;
- Strictly social or recreational services;
- Services covered elsewhere in the District's State Plan, including habilitative and mental health rehabilitative services; and
- Services which are not medically necessary.

## ASARS PROVIDER QUALIFICATIONS

In accordance with 42 C.F.R. § 440.130(d), ASARS shall be recommended by qualified physicians or other practitioners of the healing arts who are qualified to deliver substance abuse treatment services as defined by the scope of practice in the state in which the individual is licensed.

**Qualified practitioners *eligible to diagnose SUD* include**: Qualified Physicians; Psychologists; Licensed Independent Clinical Social Workers ("LICSWs"); and Advanced Practice Registered Nurses ("APRNs") when working collaboratively with a Physician to provide Assessment/Diagnostic services.

**Qualified practitioners *eligible to deliver non-diagnostic ASARS services* include**: Qualified Physicians; Psychologists; LICSWs; APRNs; Licensed Independent Social Workers ("LISWs"); Licensed Professional Counselors ("LPCs"); and Certified Addiction Counselors ("CACs I and II").

**Licensed Professional Counselors ("LPCs")** shall be licensed by the District of Columbia Department of Health ("DOH"), pursuant to Chapter 66 of Title 17 of the District of Columbia Municipal Regulations ("DCMR").

**Certified Addiction Counselors ("CACs I and II")** shall be licensed by DOH, pursuant to Chapter 87 of Title 17 DCMR.

- Licensure requirements for CACs include educational and experiential components, as well as certification by the National Association of Alcohol and Drug Abuse Counselors – National Certification Commission ("NAADAC-NCC").
- Supervisory CACs shall be advanced practice addiction counselors, LPCs, clinical psychologists, clinical social workers, marriage and family therapists, physicians, or registered nurses; and hold one of the following: 1) current CAC II certification in substance abuse counseling; 2) certification through the NAADAC-NCC or National Board of Certified Counselors ("NBCC"); or 3) have documentation of a minimum of one (1) year of experience in substance abuse counseling and at least one hundred (100) hours of didactic training.

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## ASARS FACILITIES/PROGRAM REQUIREMENTS

In accordance with § 2331.4 of Title 29 DCMR, all substance abuse treatment facilities and programs shall be enrolled as Medicaid providers in order to be eligible for reimbursement.

The DOH Addiction Prevention and Recovery Administration ("APRA") is the state agency responsible for regulating and certifying substance abuse treatment facilities and programs. ASARS shall be delivered in substance abuse treatment facilities and programs that are APRA-certified in one or more of the following categories:

- Non-hospital Inpatient Detoxification, as defined in § 2399 of Title 29 DCMR, and subject to ASARS Program Exclusions described above;
- Non-hospital Residential Treatment;
- Intensive Outpatient Treatment;
- Narcotic/Opioid Outpatient Treatment; and/or
- Outpatient Treatment

Non-hospital facilities and programs delivering ASARS to Medicaid beneficiaries shall be subject to both DHCF and APRA policies, which include, but are not limited to, maintaining standards for:

- Administrative operations in areas such as: practice ethics; quality improvement; policies and procedures; relationships with external entities and contractors; health and safety management; patient rights and privileges;
- Clinical operations in areas such as: levels of patient care standards; intake and screening; rehabilitation/treatment planning; crisis intervention; clinical emergencies; referrals; staff development;
- Protection of patient rights and privileges, including a well-publicized complaint/grievance system; and
- Space, staffing, and financial management, including one (1) mandatory cardiopulmonary resuscitation ("CPR") certified staff member to be present during all hours of operation.

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## ASARS: TREATMENT FRAMEWORK

The treatment framework for ASARS is based on four (4) levels of care established by the American Society for Addiction Medicine ("ASAM"). A typical course of treatment anticipates continuity of services across multiple levels of care, and assumes two factors: 1) that a beneficiary enters treatment at the level of care most consistent with the presenting needs and 2) that subsequent authorizations include all lower levels of care in a graduated fashion.

Delivery of ASARS is based on the treatment episode. The treatment episode is the period between a beneficiary's admission to treatment for SUD and the termination or discharge from services prescribed in the rehabilitation (or treatment) plan, as defined in D.C. Official Code § 7-3002(10). A single treatment episode may include multiple levels of care, subject to the limitations described in "ASARS: Descriptions of Services".

The average lengths of treatment episodes at each level of care are as follows:

**A.** **Level IV**: From three (3) to five (5) days (i.e., Medically Managed Intensive Inpatient Detoxification)

**B.** **Level III**: Approximately twenty-eight (28) days (i.e., Residential Substance Abuse Treatment)

**C.** **Level II:** Thirty (30) to forty-five (45) days

**D.** **Level I**: Approximately one hundred twenty (120) days (excluding Medication Assisted Treatment)

A course of ASARS treatment incorporates interdisciplinary approaches to rehabilitation (treatment) plan development, excluding mental health services. Comprehensive clinical care coordination (CCC) services are intended to improve outcomes by linking a beneficiary to health, medical, and social services that aid addiction recovery.

Due to the chronic nature of SUD, a beneficiary may relapse during a 12-month period after having already completed one (1) full course of treatment (i.e., at least two (2) of the above levels of care). ASARS treatment is organized to allow a beneficiary to access a second course of treatment, in addition to services related to higher levels of care, if relapse occurs. Prior authorization from DHCF is required if relapse requires a beneficiary to repeat treatment in a level of care that was previously received in the same 12-month period.

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## ASARS: DESCRIPTIONS OF SERVICES

i. **Assessment/Diagnostic** services represent initial evaluation, as well as initial and ongoing collection of relevant information about a beneficiary who may require access to ASARS treatment. The assessment instrument shall incorporate ASAM patient placement criteria.

An Assessment/Diagnostic may be 1) Initial; 2) Comprehensive; 3) Ongoing; or 4) Brief. Initial, Comprehensive, and Ongoing Assessment/Diagnostic services include the development and refinement of treatment plans in addition to providing referrals. Brief Assessment/Diagnostic may be used for minor updates to a beneficiary's diagnosis or treatment plan prior to transfer into a different level of care as indicated by progress with ASARS treatment. Brief Assessment/Diagnostic may also be used as a pre-screening for hospitalization and prior to a beneficiary's discharge from ASARS treatment. Initial and Comprehensive Assessment/Diagnostic shall be performed once per treatment episode. Clinical Care Coordinators shall determine the frequency of Ongoing and Brief Assessment/Diagnostic services.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Additional units require prior authorization from DHCF, obtained by submitting a request through APRA. Limitations for Assessment/Diagnostic services, per treatment episode, are as follows:

1. *Initial Assessment/Diagnostic services* are required to determine an individual's need for substance abuse treatment, and shall not exceed four (4) units;
2. *Comprehensive Assessment/Diagnostic services* are required in order to initiate a treatment episode, and shall not exceed sixteen (16) units;
3. *Ongoing Assessment/Diagnostic services* shall not exceed ninety-two (92) units; and
4. *Brief Assessment/Diagnostic services* shall not exceed eight (8) units.

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs

**D.** Qualified Practitioners: Assessment/Diagnostic services may be provided by qualified practitioners as follows:

1. *Initial Assessment/Diagnostic services* shall be provided by the following: Qualified RNs, LISWs, LPCs, and CACs I and II.
2. *Comprehensive, Ongoing, and Brief Assessment/Diagnostic services* shall be provided by the following: Qualified Physicians, Psychologists, LICSWs and APRNs.

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ii. **Clinical Care Coordination ("CCC")** is the initial and ongoing process of identifying, planning, coordinating, implementing, monitoring, and evaluating options and services to best meet a beneficiary's health needs during ASARS treatment. CCC focuses on linking beneficiaries across the levels of care indicated in the treatment plan, and is intended to facilitate specified outcomes that will restore a beneficiary's functional status in the community. CCC includes the identification of interventions that are consistent with the diagnosis, and monitoring compliance with appointments and participation in activities defined in the treatment plan.

Each Medicaid beneficiary receiving ASARS treatment shall be assigned a Clinical Care Coordinator. Clinical Care Coordinators are required to participate in a beneficiary's interdisciplinary team meetings in order to identify opportunities to further develop and/or update the treatment plan.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Limitations for CCC, per treatment episode, are as follows:

1. Level IV: Sixteen (16) units;
2. Level III: Sixty-four (64) units;
3. Level II: Ninety-six (96) units;
4. Level I: One-hundred ninety two (192) units
   Beneficiaries at level I and receiving long-term Medication Assisted Treatment (MAT) (methadone/buprenorphine) are allowed an additional sixteen (16) units during a treatment episode.

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs or community-based setting otherwise approved or designated by APRA

**D.** Qualified Practitioners: Qualified substance abuse counselors, limited to: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs II.

Clinical Care Coordinators, except Qualified Physicians and Psychologists, shall provide CCC under the supervision of the following practitioners: 1) LICSW; 2) APRN or RN certified in chemical dependency; 3) a supervisory CAC II; or 4) an individual with a Bachelor's degree from an accredited college or university in social work, counseling, psychology, or a closely related field, and at least two (2) full years of experience.

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iii. **Crisis Intervention** is an immediate, short-term substance abuse treatment approach that is intended to assist a beneficiary to resolve a personal crisis. Crises are events that significantly jeopardize treatment, recovery progress, health, and/or safety.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Allowable units per 12-month period are based on the following level of care structure:

1. Level IV: Thirty-two (32) units;
2. Level III: One hundred sixty (160) units;
3. Level II : One hundred twenty (120) units;
4. Level I: Eighty (80) units

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs and community-based setting otherwise approved or designated by APRA

**D.** Qualified Practitioners: Qualified substance abuse counselors, including: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs I and II

iv. **Medically Managed Intensive Inpatient Detoxification ("MMIID"), or Level IV Care,** is 24-hour, medically directed evaluation and withdrawal management. The service is for beneficiaries with sufficiently severe signs and symptoms of withdrawal from psychoactive substances such that primary medical and nursing care services are necessary.

Beneficiaries discharged from MMIID treatment shall be directly admitted into a residential substance abuse program through a "bed-to-bed" transfer unless APRA previously authorized an exception, or the client refuses admission to a residential program.

**A.** Unit of Service: A unit of service is equivalent to one (1) day as an inpatient

**B.** Limitations: An MMIID stay shall not exceed five (5) days without prior authorization from DHCF. The maximum for MMIID services is ten (10) units per treatment episode. Additional units shall be requested through APRA and prior authorized by DHCF.

**C.** Location/Setting: Free-standing, non-hospital, APRA-certified substance abuse treatment facilities/programs meeting the standards for medical detoxification personnel, as set forth in § 2364 of Title 29 DCMR.

**D.** Qualified Practitioners:

1. Licensed Physicians; or
2. Psychologists, RNs, LICSWs, APRNs, LPCs, or CACs II under the direction and supervision of a Qualified Physician and in accordance with applicable District of Columbia professional licensing laws

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v. **Substance Abuse Counseling (Individual, Group, and Family)** is a face-to-face, interactive process conducted in individual, group, or family settings and focused on assisting a beneficiary who is manifesting SUD.

The aim of Substance Abuse Counseling is to cultivate the awareness, skills, and supports to facilitate long-term recovery from substance abuse. Substance Abuse Counseling addresses the specific issues identified in a treatment plan. Substance Abuse Counseling shall be conducted in accordance with the requirements established in 29 DCMR §§ 2340, 2341, and 2343 as follows:

Individual Substance Abuse Counseling is face-to-face interaction with a beneficiary for the purpose of assessment or supporting the patient's recovery. 29 DCMR § 2340

Group Substance Abuse Counseling facilitates disclosure of issues that permit generalization to a larger group; promotes help-seeking and supportive behaviors; encourages productive and positive interpersonal communication; and develops motivation through peer pressure, structured confrontation and constructive feedback. 29 DCMR § 2341

Family Substance Abuse Counseling is planned, goal-oriented therapeutic interaction between a qualified practitioner, the beneficiary, and his or her family. A family member is an individual who lives in the same household as the beneficiary and has a significant relationship with him/her. 29 DCMR § 2343

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Substance Abuse Counseling shall not be provided in conjunction with Medication Management. Group and Family Counseling services shall be directed exclusively toward the recovery of a Medicaid beneficiary enrolled in ASARS treatment. Limitations for Substance Abuse Counseling, per treatment episode, are as follows:

1. Level IV: *Individual*: Not to exceed twenty (20) units; *Group*: Not to exceed twelve (12) units; *Family*: Not to exceed four (4) units

2. Level III: *Individual*: Not to exceed thirty-two (32) units; *Group*: Not to exceed eight hundred ninety-six (896) units; *Family*: Not to exceed sixteen (16) units

3. Level II: *Individual*: Not to exceed twenty-four (24) units; *Group*: Not to exceed two hundred sixteen (216) units; *Family*: Not to exceed twenty-four (24) units

4. Level I (Beneficiaries also receiving methadone maintenance or buprenorphine): *Individual*: Not to exceed forty-eight (48) units; *Group*: Not to exceed one hundred ninety-two (192) units; *Family*: Not to exceed twelve (12) units

5. Level I: *Individual*: Not to exceed thirty-two (32) units; *Group*: Not to exceed three hundred eighty-four (384) units; *Family*: Not to exceed sixteen (16) units

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Additional allowances for Substance Abuse Counseling services shall be established by the Clinical Care Coordinator, subject to the beneficiary's level of care.

**C.** Location/Setting: APRA-certified substance abuse treatment facilities/programs; community-based setting otherwise approved or designated by APRA; and private practices with qualified practitioners authorized to provide substance abuse counseling according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*)

**D.** Qualified Practitioners: Substance abuse counselors, including: Qualified Physicians, Psychologists, LICSWs, APRNs, RNs, LISWs, LPCs, and CACs I and II

**vi.** **Medication Management** is the coordination and evaluation of medications consumed by beneficiaries. It includes monitoring of potential side effects, drug interactions, compliance with doses, and efficacy of medications. Medication Management includes the evaluation of a patient's need for MAT, the provision of prescriptions, and ongoing medical monitoring/evaluation related to the use of the psychoactive drugs.

**A.** Unit of Service: A unit of service is one 15-minute increment, pursuant to billing criteria established by DHCF

**B.** Limitations: Medication Management shall not be conducted in conjunction with Substance Abuse Counseling. The maximum for Medication Management is ninety-six (96) units per treatment episode.

**C.** Location/Setting: Substance abuse treatment facility program certified by APRA; or community-based setting otherwise approved or designated by APRA; private practice offices of individuals authorized to provide medication management services according to their licensure pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*)

**D.** Qualified Practitioners: Licensed practitioners, including: Qualified Physicians or APRNs and PAs who are supervised by qualified physicians

**vii.** **Medication Assisted Treatment ("MAT")** is the use of pharmacotherapy as long-term treatment for opiate or other forms of dependence. MAT includes medication dosing used in conjunction with Substance Abuse Counseling. Beneficiaries enrolled in MAT shall also be enrolled in Substance Abuse Counseling. MAT is described in Supplement 1 to Attachment 3.1-B, page 19.

**Reimbursement Methodology: Other Diagnostic, Screening, Preventive and Rehabilitative Services, i.e., Other Than Those Provided Elsewhere in this Plan (continued)**

A. The following Adult Substance Abuse Rehabilitative Services (ASARS), when provided by facilities or programs certified by the Addiction Prevention and Recovery Administration (APRA) in the Department of Health, are available to all Medicaid eligible individuals who elect to receive, have a legally authorized representative select on their behalf, or are otherwise legally obligated to seek rehabilitative services for substance use disorder. Medicaid-reimbursable ASARS include the following categories of services:

i. Assessment/Diagnostic
ii. Clinical Care Coordination
iii. Crisis Intervention
iv. Substance Abuse Counseling
v. Medically Managed Intensive Inpatient Detoxification
vi. Medication Management
vii. Medication Assisted Treatment

B. ASARS shall be reimbursed according to a fee schedule rate for each ASARS identified in an approved treatment plan (i.e., rehabilitation plan, as defined in D.C. Official Code §7-3002(10)). Reimbursement shall not be allowed for any costs associated with room and board.

C. A rate for each category of ASARS shall be established based on an analysis of comparable services rendered by similar professionals in the District of Columbia and other states.

The reimbursable unit of service for Assessment/Diagnostic; Clinical Care Coordination; Crisis Intervention; Substance Abuse Counseling; and Medication Management shall be fifteen (15) minutes. Separate reimbursement rates shall be established for services eligible to be rendered in community-based, group, and family settings.

The reimbursable unit of service for Medically Managed Intensive Inpatient Detoxification shall be one (1) day.

The reimbursable unit of service for Medication Assisted Treatment shall be one (1) dose per day.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of adult substance abuse rehabilitative services. The DHCF fee schedule is effective for services provided on or after October 17, 2011. All rates are published on the state agency's website at www.dc-medicaid.com.

D. Rates shall be consistent with efficiency, economy and quality of care.